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V 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of the Medicare recertification survey conducted at your facility on 1/06-09/09. A separate Statement of Deficiencies was generated as a result of the State Licensure survey conducted at the same time. The census was 90. 11 clinical records were reviewed. 5 patients were interviewed. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. The following regulatory deficiencies were identified:	V 000		
V 101	494.20 COMPLIANCE W/FED, STATE, & LOCAL LAWS The facility and its staff must operate and furnish services in compliance with applicable Federal, State, and local laws and regulations pertaining to licensure and any other relevant health and safety requirements. This STANDARD is not met as evidenced by: NAC 449.5465 Patient care: Licensed practical nurses and dialysis technicians. (NRS 449.037) 1. The provisions of NAC 449.501 to 449.5795, inclusive, do not prohibit a licensed practical nurse from practicing in accordance with the regulations adopted by the State Board of Nursing. If a licensed practical nurse acts in the	V 101		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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V 101	Continued From page 1 capacity of a licensed practical nurse during the treatment of a patient of a facility, the licensed practical nurse must be certified to give intravenous injections by a board that is approved by the State Board of Nursing. 2. A member of the staff of a facility who acts in the capacity of a dialysis technician at the facility must be qualified in accordance with the provisions of NAC 449.5705 to 449.5775, inclusive. If the facility determines that the member of the staff is not qualified pursuant to those provisions, the facility shall not allow the member of the staff to act in the capacity of a dialysis technician until the member of the staff becomes qualified pursuant to those provisions. (Added to NAC by Bd. of Health by R130-99, eff. 8-1-2001) NAC 449.570 General qualifications; identification to be worn during training; provision of care; requirements to act as preceptor. (NRS 449.037) 1. A person may not act as a dialysis technician at a facility unless he is qualified in accordance with the provisions of NAC 449.5705 to 449.5775, inclusive. 2. If a dialysis technician receives training in any area of a facility in which treatment is provided to a patient of the facility, the dialysis technician shall, during the period in which he is located in that area, wear a tag or similar device that identifies the dialysis technician. The tag or similar device must be worn in a visible manner. NAC 449.571 Program of training: Curriculum; duties of instructor; written examinations. (NRS 449.037) 1. Each program for training a dialysis technician provided by a facility must consist of a written curriculum that specifies the objectives for each	V 101		

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V 101	Continued From page 2 portion of the course. 6. Except as otherwise provided in subsection 7, each dialysis technician specified in subsection 5 must complete a written examination. The examination must include each of the subjects specified in subsections 2 and 3. If the dialysis technician intends to cannulate a dialysis access during the treatment of a patient of the facility or administer normal saline, heparin or lidocaine to that patient, the examination must include the subjects specified in subsection 4. To pass the written examination, the dialysis technician must achieve a score of not less than 80 percent on each of the subjects required to be included in the written examination pursuant to the provisions of this subsection. NAC 632.249 Identification by appropriate title required; identification requirements for telenursing. (NRS 632.120) 1. Each registered nurse, licensed practical nurse, certified nursing assistant, nursing student and nurse certified in an advanced speciality shall identify himself by his appropriate title: (a) When recording information on a record; (b) When introducing himself to a client, patient or prospective patient; and (c) On a name tag which: (1) Includes, at a minimum, his first name and the first initial of his last name, and his title; (2) Is prominently displayed on his clothing; and (3) Is clearly legible from a distance of at least 3 feet. 2. In addition to the requirements set forth in subsection 1, each registered nurse, licensed practical nurse, certified nursing assistant, nursing student and nurse certified in an advanced speciality shall, when practicing telenursing, identify orally the state in which he is	V 101		

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V 101	Continued From page 3 licensed or certified. 3. As used in this section: (a) " Nurse certified in an advanced specialty " includes, but is not limited to, a clinical nurse specialist, advanced practitioner of nursing, certified registered nurse anesthetist and attendant as that term is defined in NAC 632.565. (b) " Telenursing " means the provision of nursing care or advice from a remote location through the use of telecommunications equipment, including, but not limited to, a telephone, teletype, facsimile machine and any equipment capable of transmitting a video image. (Added to NAC by Bd. of Nursing, eff. 7-11-96; A by R211-97, 9-25-98; R122-01, 12-17-2001) NAC 632.455 Procedures not delegable to licensed practical nurses. (NRS 632.120) A licensed practical nurse may not administer intravenously: 1. Any drug other than an antibiotic, steroid or histamine H2 receptor antagonist; 2. Any drug which is under investigation by the United States Food and Drug Administration, is an experimental drug or is being used in an experimental method; 3. Any antineoplastic medications; 4. Colloid therapy, including hyperalimentation; or 5. Any medication administered by intravenous push. [Bd. of Nursing, § V subsec. C, eff. 8-21-81]-(NAC A 1-24-92; R102-03, 10-30-2003; R091-04, 8-13-2004) Based on personnel file review, observation and staff interview, the facility failed to follow the directives of the Nevada Administrative Code (NAC) pertaining to (1) The Patient Care	V 101		

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V 101	Continued From page 4 Technician (PCT) training program (NAC 449.570 (PCT #1 and PCT #7) and NAC 449.571 (PCT #1, PCT #7, PCT #8)); (2) Licensed Practical Nurses (LPN) administration of intravenous therapy (NAC 449.5465 and NAC 632.455) for LPN #1; and nurse identification (NAC 449.5465 and NAC 632.249). Finding include: NAC 449.570 PCT Identification. During observation of the facility's start up time at 4:30 AM on 1/07/09, it was noted that PCT #1 and #7 (both trainees) were not wearing facility identification badges. Both employees acknowledged that they did not have identification badges. NAC 449.571 PCT Training Review of the training materials during the survey process failed to disclose a roster of attendance for each technician enrolled in the course. Employees PCT #1, PCT #7, and PCT #8 were currently in the training process. Staff were unable to produce such a roster when requested. Nurse Co-manager #1 was interviewed on 1/08/09. When interviewed about evaluation of the training course enrollees' progress, at least on a weekly basis, she revealed that it was an informal process with no regularity or written documentation. Module post tests were not being completed or evaluated by the preceptor at the end of each training module. (Note: Therefore their strengths and/or weakness in a particular area of training could not be included in determining their progress in completing the	V 101		

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V 101	Continued From page 5	V 101		

course.)

PCT #8 had been involved in the training course since November 2008. Review of her training curriculum workbooks revealed module post tests, some of which were only partially completed. They had not been graded as of the time of the survey. When interviewed on 1/08/09, the Clinical Services Specialist indicated that the module post tests were utilized by the trainee as a study guide and were not formally graded or evaluated by the preceptor. She further explained that upon completion of the training course, the trainee was given a theory class at which time, the trainee took a final examination which was a compilation of all the subject manner.

NAC 449.5465 and NAC 632.455 for LPN #1

In an interview with the Clinical Services Specialist on 1/08/09, she confirmed that LPN #1 was administering medication IVP to patients while on dialysis.

In review of patient records, it was noted that LPN #1 had administered the following drugs intravenous push (IVP):

Patient #8

Zemplar 2 mcg	12/29/08
Epogen 2200 units	12/29/08
Zemplar 2 mcg	12/31/08

Patient #3

Epogen 6600 units	1/01/09
Venofer 100 mg	12/24/08
Epogen 6600 units	12/24/08
Epogen 6600 units	12/22/08
Epogen 6600 units	12/20/08

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V 101	Continued From page 6 Venofer 100 mg 12/18/08 Epogen 6600 units 12/18/08 Further review of the clinical records revealed LPN #1 had administered intravenous push Epogen and/or Zemplar to the following patients. Patient #2 received Zemplar and Venofer IVP on 12/11/08; Patient #4 received Zemplar IVP on 12/29/08, and 12/31/0;. Patient #5 received Epogen on 12/18/08, 12/20/08, 12/22/08, and 12/27/08 and Venofer on 12/18/08, 12/24/08, and 1/1/09; Patient #6 received Epogen IVP on 12/18/08, 12/20/08, 12/22/08, 12/24/08, and 12/27/08; Patient #9 received Epogen and Zemplar IVP on 12/29/08. NAC 449.5465 and NAC 632.249 Nurse Identification. Review of the 11 clinical records revealed the entries of any medication administration, data entry or other entry in the computer system of the clinical record made by the registered nursing and licensed practical nursing staff names did not include their appropriate title as part of their entry. An interview with the Clinical Service Specialist on 1/7/09, confirmed the computer system did not include titles of nursing staff when staff entered their names.	V 101		
V 132	494.30(a)(1)(i) CDC RR-5 AS ADOPTED BY	V 132		

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V 132	Continued From page 7 REFERENCE Infection Control Training and Education Infection control practices for hemodialysis units: intensive efforts must be made to educate new staff members and reeducate existing staff members regarding these practices. This STANDARD is not met as evidenced by: Based on interview, personnel record review and facility self study education programs, it was determined the facility failed to ensure that 5 of 10 employees maintained annual infection control education. (#2, #3, #8, #9 and #10) Findings include: An interview with the Clinical Service Specialist on 1/9/09, revealed the staff obtained required in-services either online or by in-service/class format. The Clinical Service Specialist was able to demonstrate she had provided a class for infection control on 12/22/08. An interview with the Clinical Service Specialist also revealed the facility enables on-line self study programs including infection control. This on-line education tracks employees' self study courses. There was no record that Employee #2, #3, #8, #9 and #10 completed on-line infection control education programs. Review of 10 personnel records revealed five employees (#2, #3, #8, #9 and #10) had no evidence of any infection control in-services during 2008.	V 132		

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V 142	494.30(b)(1) OVERSIGHT The facility must- (1) Monitor and implement biohazard and infection control policies and activities within the dialysis unit; This STANDARD is not met as evidenced by: Based on review of the patient's admission packet, the patient education log and staff interview, the facility failed to monitor the biohazard activities of the facility by not providing the patients with either written or oral instruction on how to care for blood contaminated personal belongings for 11 of 11 clinical records reviewed patients. (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11) Findings include: Upon review of the admission packet for the patients, it was found that there was no written instructions given on how to properly launder blood contaminated personal belongings. Review of the Education Logs for Patients #1, #2, #3, #4, #5, #6, #7, #8, #9, #10 and #11, did not document any direction for the laundering of blood contaminated belongings. In an interview with Nurse Co-Manager #2 on 1/07/09, she indicated that the soiled belongings were bagged up by the staff but the patient was not given specific direction on how to launder the blood contamination articles.	V 142		
V 143	494.30(b)(2) OVERSIGHT [The facility must-] (2) Ensure that clinical staff demonstrate	V 143		

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V 143	Continued From page 9 compliance with current aseptic techniques when dispensing and administering intravenous medications from vials and ampules; and This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure compliance with aseptic techniques when dispensing and maintaining intravenous medications. Findings include: During an observation of the unit at 4:30 AM, on 1/07/09, two vials of opened medications were found in the refrigerator. A vial of TB testing material was dated 12/1/not readable. Another vial, Influenza vaccine, was dated 12/2/08. An interview was conducted with Nurse Co-Manager 2 on 1/07/09, who indicated that the facility policy was to discard opened multi-dose vials after 30 days. At approximately 4:30 AM, on 1/07/09, PCT #9 was observed drawing up heparin for the first shift of patients. She vigorously cleaned the septum of the multi dose and then drew up the first syringe of heparin. She, then, continued to insert the needles with each new syringe to be filled, without additional cleansing of the septum with alcohol. Random observations performed on 1/8/09, revealed Patient Care Technician (PCT) #8 was filling syringes of Heparin for intravenous use for the second shift of patients. This task was performed at the nurses station. PCT #8 withdrew the heparin from the multidose vial into the syringe. It was observed that instead of	V 143		

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V 143	Continued From page 10 tapping the syringe with her finger to consolidate the air that may be trapped, she would hit the syringe on the edge of the counter. The needle was not capped. PCT #8 repeated this procedure with an additional four Heparin syringes. An interview with the Clinical Service Specialist on 1/8/09, confirmed that this was inappropriate technique to consolidate air into a syringe. (Note: Because of the risk of airborne particulate contamination of the needle is present). She confirmed the PCT should have tapped the syringe with her fingers instead of hitting the edge of the counter.	V 143		
V 541	494.90 PATIENT PLAN OF CARE The interdisciplinary team as defined at §494.80 must develop and implement a written, individualized comprehensive plan of care that specifies the services necessary to address the patient's needs, as identified by the comprehensive assessment and changes in the patient's condition, and must include measurable and expected outcomes and estimated timetables to achieve these outcomes. The outcomes specified in the patient plan of care must be consistent with current evidence-based professionally-accepted clinical practice standards. This STANDARD is not met as evidenced by: Based on facility process, staff and patient interviews and record review, the facility failed to ensure that the interdisciplinary team included the patient and informed and encouraged the patient or his/her designee to participate in the development of an individualized, and comprehensive plan of care in 4 of 13 patients.	V 541		

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V 541	Continued From page 11 (#4, #12, #9 #13) The facility also failed to update the care plans and intervene with appropriate, measurable and expected outcomes with identified changes of a patient's needs in 2 of 13 patients .(#4, #9) Findings include: Interviews with the Nurse Co-manager #1 and #2 revealed that patients were invited to the care conference meetings, but the co-managers were not aware of the process of how patients were invited. An interview with the social worker on 1/8/09, revealed that he was not responsible for inviting patients to the care conference. He indicated that was the responsibility of the dietician. An interview with the dietician at approximately 10:00 AM on 1/8/09, confirmed she was responsible for inviting the patients to the care conferences. The Dietician indicated that she posted a sign on the door into the clinic area. The Dietician provided a copy of this sign which was to be used for the next care conference. The sign was printed on a regular size white sheet of paper, with black letters. The sign had printed on it, "Attention Sparks Dialysis Patients: The next Plan of Care Meeting will be Wednesday, January 28th Please let us know if you would like to attend." The Dietician indicated that she had not yet heard when the physician would be available, but the specific time would be added to the sign. The Dietician confirmed that she did not individually ask patients or their designees if they wanted to attend. She indicated that if patients wanted to attend, they would let her know. The Dietician confirmed that the only sign posted was in English, although there were several patients who did not speak or read English. The Dietician	V 541		

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V 541	Continued From page 12	V 541		

also confirmed there were two patients who were legally blind and would not be able to read the sign. The Dietician confirmed there was no accommodations made for these sub-groups of patients to be informed of the care conferences. The Dietician also confirmed that she did not have the patient or designee sign any documents to indicate whether they wanted to attend or declined the care conferences.

These interviews with the Nurse Co-managers, the Social Worker and the Dietician revealed that although they all confirmed patients did attend care conferences, they could not recall a specific patient or their designee attending a care conference.

Interviews with Patient #4 and #13 on 1/7/09, and Patient #12 on 1/9/09, revealed that they were not aware of the care conferences, nor had they ever received an invitation to attend. These patients have been patients of the facility for more than 12 months. Patient #4 denied being informed about a care plan. Patient #12 indicated that she had signed a care plan, but did not receive a copy or could remember what the care plan was for.

Patient #4 was scheduled to be dialyzed three times a week, Monday, Wednesday and Friday. Review of Patient #4's care plan revealed the interdisciplinary team signed the care plan on 10/27/08, and signed by the patient on 11/8/08, 11 days later. The care plan contained documentation by the nursing department that Patient #4 was caring for ill husband. A daily entry by a nurse on 12/16/08, indicated Patient #4's husband had expired. The social service documentation did not address any concerns regarding Patient #4's husband or home situation

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V 541	Continued From page 13	V 541		

either on the care plan or any daily entry. An interview with Patient #4 on 01/07/09, confirmed her husband had died. She indicated that he had been on Hospice and the death was a blessing but still hard for her. She indicated that although she was being contacted by the Hospice agency for grief counseling, she had not been contacted by the dialysis social worker. Patient #4 indicated that she and her husband had moved in with her daughter and son-in-law, due to both her and her husband's health needs prior to his death.

Patient #9 was scheduled to be dialyzed three times a week. Review of Patient #9's care plan revealed the interdisciplinary team signed the care plan on 10/27/08. The care plan was signed by the patient on 11/7/08, 10 days later. Documentation by nursing indicated the "main challenge for patient is to adhere to hemodialysis schedule. Patient has been electing to skip hemodialysis treatments." The social service documentation did not address any concerns regarding Patient #9's apparent noncompliance. Review of the monthly rounding reports, which were summaries of the previous month's care indicated that Patient #9 missed four treatments, rescheduled two treatments and was out of town for one treatment during September and October, 2008, prior to the care conference meeting. In November, two treatments were missed because Patient #9 was out of town. In December by 12/11/08, out of five treatments Patient #9 had rescheduled one treatment and was a no-show for another.

A daily entry note written by the dietician on 01/01/09 indicated Patient #9 continued to miss frequent treatments. The Dietician indicated that she counseled Patient #9 regarding the benefits

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of regular dialysis vs risks of missing treatments. The Dietician documented that although Patient #9 "was receptive, her adherence was questionable." The Dietician suggested the Patient #9, "Discuss the schedule with the registered nurse to see if a different schedule would be better for the patient as she does balance work and children." There was no further entries or evidence that the Dietician reported her concerns to the nursing staff, or that nursing met with Patient #9 regarding a more appropriate schedule.

An interview with Patient Care Technician (PCT) #3 at 11:45 AM on 1/9/09, revealed that Patient #9 was a young mother who also worked. PCT#3 indicated that Patient #9's dialysis treatments should have lasted 180 minutes (three hours) in length. PCT #3 indicated that Patient #9 could not get off work in time to start the treatment at the scheduled time. PCT #3 was asked why Patient #9's runs were often less than 180 minutes, usually around 120-170 minutes. PCT #3 indicated that Patient #9 needed to pick up her child so she would stop the treatments early. Review of the last nine run sheets showed no documentation of Patient #9 being informed that she needed to attempt to adhere to her schedule, there was no documentation why the time intervals were shortened. There was no documentation that the Social Worker or Nursing met with Patient #9 to resolve her schedule compliance. There was no evidence the physician was kept informed of Patient #9's need to shorten her run times.

The Social Worker confirmed during his interview that the interdisciplinary meetings were not a collaborative review of the goals and outcomes.

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V 541	Continued From page 15 He indicated the various disciplines worked independently developing separate plans. There was no evidence that the Social Worker had been involved to obtain any other solutions for #9's non-compliance, or follow-up for any psycho-social needs that Patient #4 may need. The Social service care plans for both Patient #4 and Patient #9 dated 10/28/08, indicated outcomes would be measured by KDQOL36 every 30 days. The social worker indicated that he does not use this measuring tool (KDQOL36), but could not explain why he was using it as a guide in the care plan. The social worker also confirmed that although he did indicate that outcomes would be re-evaluated in 30 days, there was no social worker documentation since 10/28/08.	V 541		
V 556	494.90(b)(1) IMPLEMENTATION OF THE PATIENT PLAN OF CARE The patient's plan of care must- (i) Be completed by the interdisciplinary team, including the patient if the patient desires; and (ii) Be signed by the team members, including the patient or the patient's designee; or, if the patient chooses not to sign the plan of care, this choice must be documented on the plan of care, along with the reason the signature was not provided. This STANDARD is not met as evidenced by: Based on staff and patient interviews, the facility failed to demonstrate that patients were encouraged to participate in the care conference process and that their choice of participating or not participating was documented. Findings include:	V 556		

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V 556	Continued From page 16 Interviews with the Nurse Co-manager #1 and #2 revealed that patients were invited to the care conference meetings, but the co-managers were not aware of the process of how patients were invited. An interview with the social worker on 1/8/09, revealed that he was not responsible for inviting patients to the care conference. He indicated that was the responsibility of the dietician. An interview with the dietician at approximately 10:00 AM on 1/8/09, confirmed she was responsible for inviting the patients to the care conferences. The Dietician confirmed that she did not individually ask patients or their designees if they wanted to attend. She indicated that stated she would post a sign on the door into the clinic area. The sign had printed on it, "Attention Sparks Dialysis Patients: The next Plan of Care Meeting will be Wednesday, January 28th Please let us know if you would like to attend." The sign would include the times of the meeting. The Dietician indicated that if patients wanted to attend, they would let her know. The Dietician confirmed that the only sign posted was in English, although there were several patients who did not speak or read English. The Dietician also confirmed there were two patients who were legally blind and would not be able to read the sign. The Dietician confirmed there was no accommodations made for these sub-groups of patients to be informed of the care conferences. The Dietician also confirmed that she did not have the patient or designee sign any documents to indicate whether they wanted to attend or declined the care conferences. Interviews with the Nurse Co-managers, the	V 556		

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V 556	Continued From page 17 Social Worker and the Dietician revealed that although they all confirmed patients did attend care conferences, they could not recall a specific patient or their designee attending a care conference. Interviews with Patient #4 and #13 on 1/7/09, and Patient #12 on 1/9/09, revealed that they were not aware of the care conferences, nor had they ever received an invitation to attend. These patients have been a patient of the facility for more than 12 months. Patient #4 denied being informed about a care plan. Patient #12 indicated that she had signed a care plan, but did not receive a copy or could remember what the care plan was for.	V 556		
V 634	494.110(a)(2)(vi) PROGRAM SCOPE [The program must include, but not be limited to, the following:] (vi) Medical injuries and medical errors identification. This STANDARD is not met as evidenced by: Based on clinical record review, staff in-service records, observations, and staff interviews, the facility failed to ensure that staff evaluated procedures to demonstrate that patients received prescribed Heparin doses in 11 of 11 charts. Findings include: Review of 11 active records revealed that documentation practices of administered Heparin during the course of the dialysis treatment were not consistent in demonstrating the amount of Heparin that was administered. Review of the 11 records all revealed inconsistent documentation	V 634		

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V 634	Continued From page 18 of the administered Heparin. Examples of these inconsistencies were demonstrated in Patient #2's clinical run sheets as follows: Patient #2 was scheduled to receive dialysis for 240 minutes (or four hours). He was to receive 2000 units (u) of Heparin as a bolus dose at the beginning of treatment and then 1000 units every hour, stopping 30 minutes before the end of the scheduled treatment for a total of 3500 units be delivered during the course of the treatment. Review of Patient #2's dialysis run sheets revealed: For 12/9/08 1) The medication administration section indicated that a Heparin bolus of 2000 u was administered at 10:05 AM and 3500 units of Heparin were administered by bolus/infusion at 14:35 (2:35 PM). 2) The intradialytics documentation of the four hour treatment period revealed that Heparin was not charted in the column for Heparin administered until 12:24 PM, and 3500 was documented. 3) In the narrative notes section, the nurses and patient care technicians documented a running tally of volume of Heparin infused every 30 minutes. These totals started at 10:47 AM and ended at 3:17 PM (3.5 hrs). These totals were 0.9, 1.2, 1.6, 2.1, 2.5 and 3.3, but did not include the final amount of 3.5. An interview with nursing staff on 1/6/09, revealed the documentation was how many units had been given so far (for example 900, 1200, 1600), but that there was no evidence the patient received the 3500 units of	V 634		

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V 634	Continued From page 19 Heparin as ordered. For 12/11/08 1) There was no Heparin doses documented in either the column for Heparin or the narrative notes until 1:39 PM when a total of 3500 was documented in the column dose for heparin. For 1/3/09: 1) The Heparin column documented the Heparin dose as 3.6, 2.6, 3, 0.6 by the same nurse. There was no explanation if another syringe had been added or if the machine had malfunctioned. Interviews with nursing staff on 1/7/09 and 1/98/09 revealed that the Heparin syringes were filled with approximately 0.5 to 1.0 cubic centimeter (cc) more of the Heparin 1000 u/cc dose than ordered to accommodate for the machine's settings. It was also confirmed that nursing staff were to make a visual observation of the volume of fluid remaining in the syringe and document this volume. The Co-Nurse Manager #2 indicated on 1/6/09, that if the Heparin syringe required additional Heparin during the dialysis of a patient, an additional Heparin syringe would be added. She confirmed there were no standing orders to allow for this procedure. She also indicated the physician would not be notified. Observations on 1/7/09 and 1/8/09, revealed one Patient Care Technician preparing Heparin doses for patients. An observation on 1/7/09 at 5:00 AM revealed PCT #4 placing the filled Heparin syringes into the dialysis machine for ongoing administration during the treatment. She confirmed that she did not compare the syringe of Heparin with what was ordered or to make sure the syringe was filled with the additional volume.	V 634		

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V 634	Continued From page 20 She confirmed there was no documentation as to how full the syringe was at this time. An interview with the Clinical Service Specialist on 1/8/09, revealed that she had given two in-services for accurate Heparin documentation in December, but confirmed that not all staff attended and there was no method in place to audit the daily run sheets to ensure compliance.	V 634		
V 638	494.110(b) MONITORING PROGRAM IMPROVEMENT The dialysis facility must continuously monitor its performance, take actions that result in performance improvements, and track performance to ensure that improvements are sustained over time. This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to promote continuous monitoring of the unit's performance. Findings include: Review of the daily dialysis treatments revealed inconsistencies, deviations in the prescription or incomplete data being recorded for all patient records reviewed in the sample. Areas included; Blood Flow Rates (BFR), Heparin dosages, changes in treatment duration, lack of patient assessment data, lack of patient monitoring while on dialysis, and failure of the computer to record the entire dialysis treatment. In some instances, there was a lack of adequate documentation of unusual or adverse events. The surveyors were unable to determine if unusual or adverse events occurred which resulted in the reduced BFR, shortened durations of the treatments, alterations	V 638		

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in Heparin doses or other fluctuations of the treatment orders.

One example of the above inconsistencies occurred that did enable the surveyors to demonstrate this lack of continuous monitoring.

Patient #11 was dialyzed on 1/6/09. This surveyor observed the patient being taken from the facility via an ambulance. When Nurse Co-Manager #2 was asked what had happened, she indicated that the patient was not feeling well enough to go home by himself and that he had no ride. She further indicated that he had experienced chills and vomiting. Upon further questioning, she disclosed that the patient had complained of flu like symptoms prior to coming to dialysis. Once on the machine, he had several episodes of vomiting and continued to have chills. The doctor on call was notified and it was decided to have him evaluated at the emergency room following completion of his treatment. Blood cultures were drawn while still at the facility. When the treatment sheet was reviewed, the data collection by the PCT indicated no nausea or vomiting and did not mention the chills. When the pre-assessment was completed by the nurse, nausea and vomiting was noted but there was no mention of the chills. In reviewing the intradialytics or documentation of the patient's treatment, there was no mention of the continued chilling or the episodes of vomiting. The only comment was "patient alert." The discharge status stated admitted to the hospital as an inpatient. There was no clarification as to why he went to the hospital or that the physician had been notified.

When the Clinical Services Specialist and the

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V 638	Continued From page 22 Nurse Co-managers were questioned about these areas of concern (blood flow rates, heparin doses, changes in treatment duration, lack of patient assessment data, lack of patient monitoring while on dialysis, and failure of the computer to record the entire dialysis treatment) throughout the survey process, they acknowledged that they were unaware of the areas of concern. (with the exception of heparin doses). They further explained that the daily treatment records remained in the computer and were seldom printed out. They further disclosed that the daily treatment records were not reviewed or checked for completeness or accuracy by the licensed staff. They were unaware if there were problems with the computer correctly recording the events involved in the dialysis treatment. The Clinical Services Specialist and the Nurse Co-Managers acknowledged that more comprehensive documentation needed to be utilized in the case of an unusual or adverse event. Cross reference to V726	V 638		
V 693	494.140(e)(3) PATIENT CARE DIALYSIS TECHNICIANS [Patient care dialysis technicians must-] (3) Have completed a training program that is approved by the medical director and governing body, under the direction of a registered nurse, focused on the operation of kidney dialysis equipment and machines, providing direct patient care, and communication and interpersonal skills, including patient sensitivity training and care of difficult patients.	V 693		

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V 693	Continued From page 23 This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to properly document the successful completion of the Patient Care Technician (PCT) program for 1 PCT of 4 PCTs that were trained. (PCT #4) Findings include: PCT #4 had been employed by the facility since 5/31/07. Review of her personnel file disclosed copies of post tests for the following module of instruction; Medications, Treatments, Patient Information, Accesses, Basic Orientation, Integration of Care, and Machines. However, none of the post tests had a grade to show that she had successful passed the testing for the specific modules. The record did not contain any documentation of the time spent in the classroom and the clinical setting while in the training program.	V 693		
V 726	494.170 MEDICAL RECORDS The dialysis facility must maintain complete, accurate, and accessible records on all patients, including home patients who elect to receive dialysis supplies and equipment from a supplier that is not a provider of ESRD services and all other home dialysis patients whose care is under the supervision of the facility. This STANDARD is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to ensure that clinical records contained complete and accurate documentation of treatment records in 11 of 11 records reviewed. Findings include:	V 726		

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V 726	Continued From page 24 Review of the clinical records revealed a computerized treatment form used for each treatment. These forms included a section identified as a "Pretreatment Data Collection and Assessment" section. The data section was completed by the patient care technician, the assessment section was completed by the registered nurse. This information included vital signs, gastric, cardiac, mental, mobility, edema and access site information/assessment as well as opportunity to document other identified needs. These forms also included a "Posttreatment Data Collection and Assessment" section. Review of the 11 active clinical records revealed there were no post-treatment assessment evaluations performed by the registered nurses. In 11 of 11 charts, these sections included the statement "no data" or "N/A (not applicable). There was no data collected by the patient care technicians or assessments documented by the registered nurses. Review of these records could not identify why treatment times were below the prescribed time, why heparin doses were below or above the prescribed order, or if vital signs fluctuated, was the patient stable at discharge. Interviews with the two Co-manager registered nurses confirmed that patients were observed during treatments, but that no post-assessment treatment evaluation was done. An interview with the Clinical Service Specialist (CSS) on 1/6/09, confirmed the computerized treatment forms included a section that was identified as "Posttreatment Data Collection and Assessment" that was to be completed by the	V 726		

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V 726	Continued From page 25 nurse. The CSS stated this section was part of the treatment form and was to be included in the care of the patient. Cross reference to V638	V 726		